

FEDERAL SECURITY AGENCY

National Office of Vital Statistics

FILED SEP 24 1948

Registration District No.

318

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

Primary Registration District No.

1003

State File No.

31443

Registrar's No.

8140

1. PLACE OF DEATH:

(a) County.....
(b) City or town..... **St. Louis**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: **Homer G Phillips Hospital**
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution **23 days**
(Specify whether
In this community **13 years**
years, months or days)

3. (a) PRINT FULL NAME **Elizabeth Smith**

3. (b) If veteran,
name war **no**

3. (c) Social Security No.

4. Sex **Female** 3. 5. Color or race **Negro** 6. (a) Single, widowed, married, divorced **Married**

6. (b) Name of husband or wife **Roosevelt Smith** 6. (c) Age of husband or wife if alive **abt. 41** years

7. Birth date of deceased **November 18th 1910**
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
37 9 27 hr. min.

9. Birthplace **Pickensville Co. Alabama**
(City, town, or county) (State or foreign country)

10. Usual occupation **Receptionist**

11. Industry or business **physician's office**

12. Name **Mack Nall**

13. Birthplace **Fayetteville Alabama**
(City, town, or county) (State or foreign country)

14. Maiden name **Nannie Bounds**

15. Birthplace **Columbus Mississippi**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mary Williams**

(b) Address **785a Aubert Av.**

17. (a) **Burial** (b) Date thereof **9/20/1948**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Washington Park**

18. (a) Signature of funeral director **Chas. J. Gates**

(b) Address **4109 1/2 Finney Ave.**

19. (a) **SEP 17 1948** (b) **J. J. Braseck**
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St. Louis**
(c) City or town **785 A Aubert**
(If outside city or town limits, write "RURAL")
(d) Street No. **12** (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept.** day **15**
year **1948** hour **3** minute **20 AM**

21. I hereby certify that I attended the deceased from **Aug. 23**, 19**48**, to **Sept. 15**, 19**48**,
that I last saw her alive on **Sept. 15**, 19**48**,
and that death occurred on the date and hour stated above.

Immediate cause of death **Carcinoma of Cervix with Metastasis** Duration **Undet.**

Due to.....

Due to.....

Other conditions **None**
(Include pregnancy within 3 months of death)

Major findings:
Of operations.....

Of autopsy **None**

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify).....

(b) Date of occurrence.....

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature **John B. Clayer** (M. D. or other)

Address **2601 N Whittier** Date signed **9/17/48**

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Thomas J. Pater

Licensed Embalmer No. 4059

P. O. Address. 407 7th

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.